IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF IOWA

WESTERN DIVISION

DEBRA D. MORRIS,
Plaintiff,
vs.
LARRY G. MASSANARI,[(1)]
Acting Commissioner of Social Security,
Defendant.

No. **C00-4164-MWB**

REPORT AND RECOMMENDATION

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I. INTRODUCTION

The plaintiff Debra D. Morris ("Morris") appeals the denial of her claim for Title XVI supplemental security income ("SSI") benefits. Morris argues Administrative Law Judge ("ALJ") Virgil E. Vail erred in finding Morris was able to perform her past relevant work; rejecting the opinion of Steven B. Mayhew, Ph.D., who evaluated Morris; and generally, finding Morris was not disabled for purposes of the Social Security Act. The Commissioner resists Morris's claims, asserting the ALJ's decision is supported by substantial evidence in the record.

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

Morris filed an application for SSI benefits on June 16, 1998, alleging a disability onset date of June 1, 1995. (R. 108-11) Her application was denied initially (R. 85-89), and on reconsideration. (R. 94-97) Morris then requested a hearing, which was held before the ALJ in Spencer, Iowa, on March 1, 2000. (*See* R. 19) Attorney David Scott represented Morris at the hearing. Morris, her mother Cora D. Griffin, and Vocational Expert ("VE") Tom Audet, appeared and testified at the hearing. The ALJ held the record open for the receipt of additional information. After reviewing the entire record, the ALJ ruled on June 14, 2000, that Morris was not entitled to benefits. (R. 8-26) On October 3, 2000, the Appeals Council of the Social Security Administration denied Morris's request for review (R. 4-5), making the ALJ's decision the final decision of the Commissioner.

Morris filed a timely complaint in this court on November 29, 2000, seeking judicial review of the ALJ's ruling (Doc. No. 1). Pursuant to Administrative Order #1447, entered September 20, 1999, by Chief Judge Mark W. Bennett, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B) for the filing of a report and recommended disposition. Morris filed a brief supporting her claim on May 24, 2001 (Doc. No. 8). On July 6, 2001, the Commissioner filed his brief. (Doc. No. 9) The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of Morris's application for benefits.

B. Factual Background

1. Introductory facts and Morris's daily activities

Morris is seeking benefits for disability due to a history of "complications from generalized muscular and joint pain, fibromyalgia, seizure activity, and depression." (Doc. No. 8, p. 1) At the time of the hearing in March 2000, Morris was thirty-six years old, widowed,[(2)] and living with her two teenage children. (R. 37-38)

Morris completed a portion of her junior year in high school before quitting school. (R. 40) After high school, she tried attending cosmetology classes, but was unable to perform the necessary hand movements (such as rolling, perms, and pin curls) without experiencing pain. (*Id.*)

Morris testified that prior to coming to Iowa, she had a substance abuse problem, but she had been clean for ten years. (R. 41) Morris said she moved from California to the Spencer, Iowa, area in about 1990, apparently at the time she and her husband separated (*see* R. 39), because her mother and some cousins live in the area. (R. 42)

Morris said when she was between the ages of 10 and 13, she was treated for some problems relating to her "ankles being very weak." (*Id.*) A podiatrist treated her with "electrodes and heating devices and things." (*Id.*) She said she has always had back problems. When she delivered her children, she received "the spinals," and she has "two spurs on my back, that I think possibly it caused me pain from that, from those needles." (*Id.*) She also said she has had problems with viruses and strep throat, and she had "a lot of penicillin in my day." (*Id.*)

When Morris moved to Iowa, she got a job at Shopko, where she worked for about one month. (R. 42-43) She then went to work at IBP in Hartley, Iowa, doing cleanup at night. She said the cleaning work was "extremely hard work on [her] back," because it involved a lot of work with her arms over her head. "They used to squeegee the ceilings from water, and from having my arms up and over, I would get dizzy to almost passing out." (R. 43) She quit the IBP job after being there about four months. (*Id.*)

Morris then went to work at National Spencer:

I first worked on the benches with some ladies packing things and that was too physical work for me, so they put me on a rod machine. Which I just stood in front of and I - it was really greasy and oily and I tried to find the better job."

(R. 44) She next went to work at Claire's, a jewelry store in a mall in Spencer. She liked the job, but it involved a lot of standing and a lot of working with her arms raised above her shoulders and head. (R. 44) She stated, "[W]henever I have my arms up too long, they'll fall asleep. And I don't have very good holding on skills, I drop a lot of things. I can not hold a glass of water in my hand for a long period of time, I will, you lose control." (*Id.*) She said Dr. Robison[(3)] has told her this problem is caused by carpal tunnel or tendinitis. (*Id.*)

After working at Claire's for about a month, Morris went to work at Nelson Hearing Aide Center doing telemarketing. She really liked the job, which allowed her to sit at a computer, and she felt she was good at it. (R. 44-45) Dr. Robison had limited her to three hours of work per day due to her back problems. Her employer tried to accommodate her difficulties by providing a special chair with back support, new computers, and letting her get up and walk around as needed. (R. 45-46) Nevertheless, she said, "I just could not take it, I couldn't - the pain from my arms being extended and my head up and down motion, it just - and my back, it just hurt me to where I was unstable emotionally to stay there. I could not - it was - I don't know, I guess it's, when you have your nerves pressed too long." (R. 45) She left the job after about six months. (*Id.*) Morris said this job was in 1994 or 1995, and she has not worked since she left the telemarketing job. (R. 46)

During the same time period, Morris saw doctors in an attempt to determine the nature of her problem. As noted above, she said Dr. Robison diagnosed her with carpal tunnel syndrome. In addition, she saw a specialist at the hospital in Spirit Lake, Iowa, who performed a test that involved putting needles in her palms and forearms. Morris said the procedure was intolerably painful, and the doctor only did the test on her right side. (R. 47) She saw Dr. Robison as a follow-up to the testing, and he told her she had carpal tunnel syndrome on the right side. There was no diagnosis for the left side because she had not had the testing done on her left side. (R. 49-50)

Morris said she continued treatment for the next five years. When the ALJ asked why she needed to continue treatment, given that she was not working, Morris replied:

Just pains getting more, constant, stronger. My hands falling asleep at night. The neck - like I have when I tilt my head back so far, there's a like a blackout point where I can - if I don't, you know, straight - I will eventually blackout [sic]. That's one of the reasons I went back to them, about my back and stuff. I had depression a lot. I was sleeping a lot and then not sleeping a lot, and my sleep was really, you know, kind of, it was different a lot. It was sometimes I would just sleep constantly, constantly, sometimes I would toss and turn all night. I went - I did go a few years after that without seeing any - for anything new. Just like for the colds or whatever I would have. And then - cause I, you know, I wanted to try to get back to doing something, but in this last couple years, it[']s just been so bad that I've had to see - go back to him and say I want to get rid of this problem. And it took me until last - a couple of months ago, that he even referred me to a doctor in - to take blood samples or anything in the arthritis department. I mean, I have been going to him for almost 10 years for problems with my hands and my back.

(R. 50-51)

Morris stated she saw a Dr. Archer for a disability determination. Morris said Dr. Archer told her to have Dr. Robison start treating her for fibromyalgia. She said prior to her appointment with Dr. Archer, she had never heard the term "fibromyalgia." (R. 51-52) Dr. Robison treated her with Flexeril[(4)], and she took Temazepam[(5)] for involuntary spasms in her legs. (R. 51) Dr. Robison also had her begin doing stretching and exercises. (R. 52-53) Morris also began seeing a chiropractor twice a week, who worked with her "on stretching and keeping [her] muscles flexi[ble]." (R. 53)

Morris said she saw a Dr. Mayhew for a mental health examination related to her disability application, and he told her she "was suffering from depression and . . . anxiety attacks and stuff." He suggested she see a psychiatrist. (R. 53) The ALJ noted Dr. Mayhew suggested Morris has "somatization disorder,[(6)]" and Morris said she thought that meant she had a sleep disorder because she has sleep difficulties. (R. 53-54) She said Dr. Mayhew did not explain "somatoform disorder" to her. (R. 55) She said Dr. Mayhew told her she had limited ability to concentrate in the workplace, and she had depressive disorder. (*Id.*)

As a result of Dr. Mayhew's suggestion that she see a psychiatrist, Morris saw "Dr." Sharon Eckhart.[(7)] Morris said she saw Eckhart twice per week until Morris had a seizure, when she stopped seeing her. (R. 56)

Morris said she had had prior seizures "connected with the drugs," or that she thought were "from the drugs." (R. 57) The reference to "the drugs" reflects Morris's experimentation with drugs in prior years. She had been clean for ten years at the time of the hearing. (R. 58) While she was using drugs, she had a couple of seizure-like episodes she attributed to her drug use; however, a doctor told her she possibly

had been having petit mal seizures for a long period of time, "and that possibly I was under a lot of stress that day and the day of the grand mal." (R. 57) Morris said her dentist, Dr. Fisher, commented that the condition of her teeth may indicate seizure activity. (*Id.*) She had a significant seizure, which she referred to as a grand mal seizure, on January 16, 2000. (R. 58)

As a follow-up to the seizure, Dr. Robison sent Morris for extensive testing, including an MRI, EEG, EKG and CT scan, but all the test results were normal. (R. 58-59) Morris said that about two weeks prior to the hearing, Dr. Robison started her on Dilantin to prevent further seizures. (R. 59) Sharon Eckhart told Morris the anti-depressant she had been taking, Wellbutrin, was "not a medicine to be on if you have a tendency to have seizures." (R. 59) While under Eckhart's care, Morris tried Wellbutrin, Zoloft, and Paxil. Zoloft and Paxil made her "feel really bad," so she returned to the Wellbutrin because it made her feel the least bad of the three. (R. 59-60) After the January seizure, Morris told Eckhart she was going to discontinue taking any anti-depressants until she got a better diagnosis of what caused the seizure. Eckhart concurred, and Morris quit taking any medication. She was continuing to follow up with Dr. Robison. (R. 59-60)

Dr. Robison sent Morris to see an orthopedist in Spencer, Iowa, "to get blood levels on my arthritis." (R. 61) She saw Dr. Philip Deffer at Northwest Iowa Bone, Joint & Sports Surgeons. Morris said she went to see Dr. Deffer because her hands were hurting. She said Deffer was referring her to a rheumatologist, Joseph Fanciullo, in Sioux Falls, and she had an appointment scheduled a few weeks after the hearing. (R. 62) Morris said Dr. Deffer explained "sed rate" to her, stating "a person with normal arthritis inflammation in the hands, would be at five percent and . . . I was at 33. Though, he said it was not just in my hands, it's throughout my body." (R. 63)

Morris explained her impairment relating to her hands as follows:

The fact that they fall asleep. I have involuntary movements. I can not have, I can not hold things, I can't open doors like I use[d] to, my hands will, you know, heavy door, I use the handicap press signs. The fact that I almost dropped a baby last week. I was holding my friend[']s baby. And I almost dropped it. You know, just things that have been going on forever.

(*Id.*) She also testified about problems with her legs, saying she experiences spastic-type movements and "happy feet, . . because they won't sit still." (R. 63-64

With regard to Morris's daily activities, she stated:

Well, when I'm - when I have a good night's sleep and everything, I usually get up, and get the kids off to school. I start with the dishes because it warms my hands up, and I pretty much do dishes if there's, you know, a lot I do them in sets. Because it hurts my hands to go like this, you know, so much. And my back at the same time to have my arms going, and so after I get done with the dishes, I will usually start on the rest of the house, at like vacuuming or dusting. Try to get that done, if I can successfully get that done, I will sort laundry, and my children take my laundry downstairs for me. Because my bathroom is upstairs and my washer and dryer are downstairs. It's kind of hard, it's really hard for me to go up and down. But the kids will take the baskets downstairs for me, and then I sit down there and do laundry.

(R. 64) Morris stated she naps two to three days a week, in the middle of the afternoon. (*Id.*) She said she suffers from sleep disturbances, and takes medication frequently. "Sometimes, I'm up all night, tossing and turning. Sometimes, I sleep just kind of so sound, that I'm just stiff when I wake up, you know, I'm just achy and I wake up and feel like a mack truck has hit me." (R. 65) She said a doctor told her a person needs "a level sleep for a long amount of time," to avoid becoming "emotionally drained." (*Id.*)

Morris said at the time of the hearing, she was taking several medications, including Dilantin, Vioxx, Flexeril (Cyclobenzaprine), Tetracycline for "bacteria that gets in my face," Restoril (Temazepam) "for restless legs," Trazodone, Excedrin for migraines, and a multivitamin. (R. 65)

Morris said she had complained to Dr. Robison "for a long time" about her headaches. She took her mother with her to an appointment, "and we both were on him about the way that I'm not getting over anything." Dr. Robison referred her to Dr. Deffer, and also to a dermatologist for examination of a mole that was found to be benign. (R. 66)

Morris did not know yet whether Dilantin would control her seizures. She testified she was still having "the petit mals, the staring ones," but had not "had any big ones" since she began taking Dilantin, which she had only been on for two weeks at the time of the hearing. She stated she was taking Vioxx for arthritis, and the Cyclobenzaprine, which is a muscle relaxant, for fibromyalgia. She described Trazodone as "a sleeping agent."[(8)] (R. 66-67) Morris said that after sitting for an hour-and-a-half at the hearing, her back was "kinda hurting from sitting in the chairs." Her hands did not hurt, but were cold and "very shaky." She stated, "I can't hold a glass of water, not even a glass of water, let alone, you know, pans that are full. Constantly, strain those muscles." (R. 67)

Morris said she has an exercise routine, stating:

I do muscular stretches for the neck, the back, my legs and arms. And I've just been acquiring them through the chiropractor. You know, I see him twice a week and he's been just showing me new stretches to do and I'm just trying to do that. And I'm trying to walk, trying to start walking. But I can't - I don't get very far, I get about a block and, you know, but a block each time if I can get a half a block further, it's just going to help. I'm just trying to stay moving. Cause he told me with the arthritis that, you know, if you stay in motion, you'll be in motion. If you don't, then you won't.

(R. 67-68) She said for about a week, she had been walking to the end of her block and then back into her driveway. She stated before she began taking Flexoril, she "couldn't even hardly do the stretches." (R. 68)

Morris said she has an astigmatism, which has worsened since her last seizure. (*Id.*) She said she has migraine headaches "at least once or twice a week, but they kind of linger." (R. 69) Her migraines are exacerbated by stress, and sometimes by light and sound. (*Id.*)

Morris testified her mother helps take care of her children, driving them where they need to go. Morris said she did not have a driver's license, indicating she had to wait six months from her last seizure before she could get a license. (R. 69) However, she then clarified she had either lost her license due to an unpaid parking ticket, or let the license lapse, and she never got a new license because she did not have a car and her mother was able to drive her around. (R. 69-70) In response to the ALJ's questioning, Morris agreed she has never worked for very long at a time, or for any significant part of her life, but she stated

this was due to her health problems. (R. 70-71) She denied any recent or current marijuana use. (R. 71)

Morris's mother, Cora Griffin ("Griffin"), testified that on occasion, Morris's children would report that Morris was unable to get out of bed due to her back hurting. She said Morris has had ongoing pains in her back, and headaches, arm aches, and other body aches. (R. 73) Griffin never observed any seizure activity. She did not believe Morris was capable of holding down a job because she would be unable to sit or stand long enough to work. Griffin stated,

If I take her in the car to go somewhere, I mean, I feel like I'm putting her through torture, cause all I hear is, "ugh, ugh, ugh", you know, and I try to slow down, or I try to speed up. She's just miserable. And the judge asked about the children's school, actually she can't sit in those chairs at school. My grandson has been able to borrow the video camera, and when my granddaughter has those little music programs, he videotapes it. Takes them home to us, so she can watch it. She can't sit that long time at those - on those benches -

(R. 73-74)

2. Vocational expert's testimony

The VE summarized Morris's work experience as follows:

She worked briefly at Shopco [sic] for one month, I believe that was a cashier, checker job, which is light duty, semi-skilled work. She tried a job at a meat packing plant, BSP Pack. Night cleanup, industrial cleaner, that was four months, those are medium duty, unskilled job. She worked at National Spencer both as a packager and machine feeder, both of those jobs are considered to be medium duty, unskilled work. And then she got a job in the, in the mall in Spencer at Claire's, which is a retail jewelry store. She was hired as an assistant manager, generally we would be talking about light duty, semi-skilled work, and that was four months. And then the job she had the Nelson Hearing Aide Center was as a telemarketer, telephone solicitor, which is sedentary, semi-skilled work.

(R. 76)

The ALJ posed a hypothetical to the VE, considering a person 31-36 years of age; with a limited education, ten-and-a-half years of schooling; diagnosed with a major depressive disorder, possible somatoform disorder, possible fibromyalgia, mild bilateral carpal tunnel syndrome; possible seizure disorders, although all tests have been negative; generalized pain throughout her body; and a past history of drug abuse. (R. 76-77) "She denies using marijuana at the present, but there is evidence in the file that she has admitted to being still using marijuana."[(9)] (R. 77) The ALJ asked the VE to assume:

that this hypothetical person would be capable [of] doing activity which involves light and sedentary work activity. That she'd be able [to] stand, sit, six out of eight hours, that she would be, she would be, probably restricted from doing any highly repetitive work activity and that she should avoid working at heights and long ladders or around machinery that would be dangerous, in case she had a seizure.

(R. 77) The VE responded:

As far as like night cleanup or any meat packing work, she should not do that, that would not fit within the hypothetical or any packaging machine feeding, those were production jobs, it's going to be repetitive, so she's not going to be able to return to that. As far as the cashier/checker, I don't think she should do that cause those tend to get repetitive, and especially running products across the scanner any more, can enhance [or] cause carpal tunnel in a person with that diagnosis. Probably shouldn't do that kind of work. As far as being an assistant manager at a jewelry store, that fits within the hypothetical. And the other job that fits within the hypothetical as it's outlined, is the telemarketing job. So, those two occupations would fit within the context of the hypothetical.

(R. 77-78) The VE noted there are numerous jobs in the national economy for telemarketers. (R. 78)

Morris's attorney followed up with a hypothetical based on information contained in Dr. Mayhew's report, as follows:

[I]f the claimant had limited ability to remember and understand instructions, has difficulty listening carefully to questions, needed to be redirected on a frequent basis, and would be expected to have difficulty carrying out instructions on a consistent and reliable basis, would assume to - would be assumed to have limitations as far as sustained concentration and work pace, and if we were to assume that she was not able to interact appropriately with the general public, presumably because of some difficulties with concentration and judgment, also how would those factors affect her ability to work as an assistant manager in a jewelry store setting or as a tele - telemarketer.

(R. 79) The VE responded the hypothetical person would not be able to do either of those jobs. (*Id.*)

3. Morris's medical history

Morris's medical records are summarized in detail in Appendix A to this Report and Recommendation. The court will discuss Morris's medical history in narrative form here to the extent necessary to put the discussion of her claim into context.

The record indicates Morris was diagnosed with "mild bilateral carpal tunnel" in May 1993, after an EMG and other testing by Dr. David P. Robison. (R. 201, 198) Nothing in the record indicates Morris ever followed up with treatment for this condition. She next saw a medical practitioner in January 1994, when she saw a chiropractor for low back pain, cervical pain, and headaches. (R. 203)

The next record entry is some fourteen months later, when Morris again saw Dr. Robison on March 27, 1995. She again complained of problems with carpal tunnel and tendinitis at that time. (R. 198) Dr. Robison noted Morris was going to look for a job that did not require sitting at a desk for extended periods of time. (*Id.*) Although Morris claims a disability onset date of June 1, 1995, nothing in the record indicates she obtained any type of medical treatment from March 1995, until her initial disability

examination on December 28, 1998. At that time, she reported to Dr. Brian J. Dvorak that she had had carpal tunnel syndrome for more than five years. (R. 195-96) Morris told Dr. Dvorak her carpal tunnel syndrome and tendinitis had worsened gradually over the years. He assessed her as having bilateral carpal tunnel syndrome, chronic neck and low back pain, "suspect musculoskeletal/mechanical back pain," chronic headaches, and "possible common migraines." (R. 195) Dr. Dvorak added:

We also tested her ability to lift small objects. She could lift from waist to shoulder with 5 pounds in her forearms and did not want to try anything heavier than 5 pounds. From floor to waist, she could lift a basket weighing 19 pounds, however, this was causing pulling in her low back.

(*Id.*)

Three weeks later, on January 18, 1999, Dr. Dvorak referred Morris to a dietician for weight reduction, and suggested she talk to a physical therapist about an aerobics program. He noted Morris was a "[w]ell nourished, obese, well kept woman in no distress." (R. 194)

Morris underwent a physical Residual Functional Capacity Assessment by Dr. Dennis A. Weis on February 12, 1999. Dr. Weis found Morris could occasionally lift and carry 20 pounds; frequently lift and carry 10 pounds; stand, walk and sit about six hours in an eight-hour workday; and push and pull without limitation. He found she had occasional limitations in climbing, balancing, stooping, kneeling, crouching, and crawling, and no manipulative, visual, communicative, or environmental limitations. (R. 164-73)

Morris had a cervical spine x-ray on May 27, 1999, that showed no abnormalities. (R. 208) She next saw a doctor on June 1, 1999, when Dr. Dave Archer performed a disability evaluation arising from "neck and back pain, bilateral carpal tunnel syndrome, bilateral forearm tendonitis [sic], bilateral plantar fasciitis and migraine headaches." (R. 204) Dr. Archer noted Morris's "history is notable for declining treatment for her problem stating that 'Whenever you get opened up, your arthritis doubles' and that the physical therapy helped, but 'Lifestyles closed up so I haven't been able to have any treatment for five years'. She was a difficult, circuitous and somewhat evasive historian." (*Id.*)

Dr. Archer observed Morris to be "a well developed, well nourished white female, morbidly obese." (R. 206) She was 5'2" tall, and weighed 227 pounds. Morris described a wide range of symptoms to Dr. Archer; her description is particularly relevant here, given the ALJ's conclusion that Morris's subjective complaints lacked credibility.[(10)] Dr. Archer summarized Morris's complaints as follows:

HEENT[(11)] is remarkable for her vision deteriorating. She has not seen an eye doctor. She says her hearing is okay but "My balance is off" and she notes she has tinnitus in her left ear. She states "I get strep all the time" but has never been treated. She states "They can't do a tonsillectomy because I'm too fat". She states she has "nasal palates" (polyps?) but has had no follow up. She states she has bad teeth and just had seven of them pulled and needs to have the rest pulled. Neck, she describes pain. She states she has loss of range of motion, sore glands a lot, occasionally difficulty swallowing and "enlarged glands". She says her voice box has been damaged but she cannot say what the cause of the damage was. Pulmonary, describes dyspnea[(12)] on exertion with shortness of breath "all the time". She states "I can't tolerate the cold weather in Iowa" noting that she grew up in California. Cardiac, she states she had a murmur as a child and has chest pain from the left side of her chest all the time and "palpitations". States that she "feels weird" associated with a heart problem that she cannot describe. On gastrointestinal, she

states she has "constant heartburn", nausea, vomiting associated with migraine. She states that she is gaining weight and that she is hungry all the time and describes bloating. GU[(13)]: She refuses to have pelvic examination and has not been evaluated since 1984. She states she has "PMS bad" and "I got real emotional" and "I get wiped out" because of her menstrual problems and pelvic pain. She states that "My bladder is getting read bad" but can't really describe to me what she means by that. Apparently she has a little stress incontinence but does not wear an absorbent garment. She does not describe recurrent UTI and has not sought the attention of a physician. She states "My spine thumps like a heartbeat when I have a bowel movement" and I'm not sure what she means by this, possibly tenesmus.[(14)] On musculoskeletal, she states she has pain in her neck, shoulders, elbows, wrists, hands including all the finger joints, carpals and metacarpals, her thoracic spine, lumbar spine in all motions, hip joints, knee joints, ankle, feet including tarsals and toes. She states "My fingers aren't straight anymore" and that they are "turning" and "starting to get deformed". Neuro, she states she has "shooting pains in all four extremities, her head, back and left chest. She states she has "migraines" for four years and describes what possibly may be an aura, but describes neck pain in the occiput and frontal areas associated with nausea and treated only with over the counter medications. She describes what may be a scintillating scotoma.[(15)] Psychological, she describes depressive symptoms with short temper and occasional outbursts, becoming violent towards property but not people. Describes anxiety and "nerves", that she is "afraid of pain". Describes fear of crowds. She denies symptoms on questioning consistent with a thought disorder. However, I am not impressed that she is frankly psychotic. On activity, she states she does stretches at home but can't show me what they are during the physical exam. She says it "Takes all day to clean my house". It's hard to stand for more than five minutes without pain. She's unable to walk 100 feet or so though I note she walked without difficulty to and from the parking lot. She says that pain prevents her from doing any shopping so her children have to do it. She can't even ride in the car a block. States that she is "totally disabled" by her extremity pain.

(R. 205-06)

Dr. Archer's physical examination apparently revealed no evidence to support any of Morris's symptoms, including carpal tunnel syndrome. (R. 206-07) Both Phalen's maneuver and Tinel's sign were negative.[(16)] Regarding Morris's claim that her fingers were "turning" or "staring to get deformed," Dr. Archer noted, "What she sees in her hands is normal hyperextension of the fingers and full extension and the fact that her hands are pudgy." (R. 206) Dr. Archer's impressions were (1) somatization disorder[(17)] by DSM IV criteria; (2) possible major depression; (3) cannabis use, continuous[(18)]; (4) morbid obesity; and (5) deconditioning syndrome[(19)]. (R. 207) He noted Morris "should have no difficulty lifting and carrying except as limited by her weight and conditioning, but her current mental state will prevent her from any significant activity at all due to very poor motivation. She should have no difficult with handling, environment or special senses, at least physically." (*Id.*)

Dr. Archer added the following comment:

This lady believes herself to be totally disabled, but cannot explain why to me in any organized manner. She does not express a belief that there is any effective treatment and has declined treatment in the past. I would recommend pursuit of psychological evaluation for further refinement of diagnosis and treatment recommendations which she will require some degree of work hardening before she returns to active employment. Physically, however, there should be no problem.

(*Id.*)

On August 3, 1999, Morris underwent a psychological evaluation by Steven B. Mayhew, Ph.D. (R. 211-12) He found Morris to suffer from depressive disorder, neck and back pain, obesity, and migraine headaches; to have a limited education and limited job skills; and a global assessment of functioning (GAF) of 40.[(20)] Dr. Mayhew noted Morris might meet the criteria for an "undifferentiated somatoform disorder[(21)], but the conclusion was unclear based on the brief exam. He commented:

[Morris's] ability to remember and understand instructions appears to be fair at this point. She had some difficulty listening carefully to the questions being asked and needed to be redirected. It is suspected that this would likely happen in the work place. Her work history is fairly spotty and it appears as if she has had difficulty staying with anything for a meaningful length of time, whether it be completing her education or sustained employment. It is my expectation that she would have difficulty carrying out instructions on a consistent and reliable basis. Her immediate attention and concentration is fair, however, her sustained concentration and work pace is expected to be poor. She would appear to interact appropriately with supervisors, but would not do so with the general public. Judgment is estimated to be fair to poor. Her ability to respond to changes in the work place is estimated to be limited. It is recommended that she be considered eligible for disability benefits at this point, though medical records from Dr. Robison should be obtained and, if awarded benefits, that these be managed by a payee.

(R. 212)

Philip R. Laughlin, Ph.D., performed a Functional Capacity Assessment of Morris on August 13, 1999. (R. 174-78) He found Morris had no significant limitation in her ability to remember locations and work-like procedures, understand and remember very short and simple instructions, ask simple questions or request assistance, travel in unfamiliar places, or use public transportation. He found her to have moderate limitation in her ability to understand and remember detailed instructions and carry out very short and simple instructions, sustain an ordinary routine without special supervision and make simple work-related decisions, interact appropriately with the general public, accept instructions and respond appropriately to criticism from supervisors, get along with coworkers or peers without distracting them or exhibiting behavioral extremes, maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness, be aware of normal hazards and take appropriate precautions, and set realistic goals or make plans independently of others. (*Id.*)

Dr. Laughlin found Morris to have marked limitation in her ability to carry out detailed instructions, maintain attention and concentration for extended periods and perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances, work in coordination with or proximity to others without being distracted by them, complete a normal work-day and work week without interruptions from psychologically based symptoms, perform at a consistent pace without an unreasonable number and length of rest periods, and respond appropriately to changes in the work setting. (*Id.*) He concluded that Morris suffered from:

depressive disorder, possibly coupled with an undifferentiated somatiform [sic] disorder. The impairment is severe based upon the impairment findings and symptoms and the consistency of the file. The claimant does not meet or equal Listing Impairment. The evidence in file is consistent with the

allegations, and no inconsistencies across sources of information are noted. The claimant's allegations are credible to the extent that he/she is limited as outlined on the attached [Mental Residual Functional Capacity Assessment]. The claimant does manifest significant restrictions of function, with sustained pace, concentration and attention, and adaptation/executive function.

(R. 178) Dr. Laughlin also noted Morris's "[s]ubstance use appears to be marginal and not substantially related to the present impairments." (*Id.*)

Dr. Laughlin also performed a Psychiatric Review Technique, noting a residual functional capacity assessment was necessary because Morris had been found to have a significant impairment that did not meet or equal a listed impairment. (R. 179) In his psychiatric review, Dr. Laughlin found Morris had no evidence of organic mental disorders; schizophrenic, paranoid, and other psychotic disorders; mental retardation, autism, or anxiety related disorders; personality disorder or substance abuse disorders. (R. 179-87) He found Morris to have disturbance of mood, accompanied by full or partial manic or depressive syndrome evidence by depressive disorder. Morris complained of physical symptoms for which there were no demonstrable organic findings or known physiological mechanisms evidence by provisional-undifferentiated somatoform disorder. (*Id.*)

Dr. Laughlin found Morris's activities of daily living and maintaining social functioning to be moderately limited, and she had frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner. Morris had no limitations regarding episodes of deterioration or decompensation in work or work-like setting which would cause her to withdraw from the situation or experience exacerbation of signs and symptoms. (*Id.*)

On September 27, 1999, Beverly Westra, Ph.D., performed a Mental Residual Functional Capacity Assessment of Morris (R. 188-92). Dr. Westra found Morris to have no significant limitation in her ability to remember locations and work-like procedures, understand and remember very short and simple instructions, carry out very short and simple instructions, perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances, sustain an ordinary routine without special supervision, work in coordination with or proximity to others without being distracted by them, make simple work-related decisions, interact appropriately with the general public, ask simple questions or request assistance, accept instructions and respond appropriately to criticism from supervisors, get along with coworkers or peers without distracting them or exhibiting behavioral extremes, maintain socially appropriate behavior, adhere to basic standards of neatness and cleanliness, be aware of normal hazards and take appropriate precautions, travel in unfamiliar places, or use public transportation. She found Morris to have moderate limitation in her ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods, complete a normal work-day and work week without interruptions from psychologically based symptoms, perform at a consistent pace without an unreasonable number and length of rest periods, respond appropriately to changes in the work setting, set realistic goals, or make plans independently of others. (*Id.*)

Dr. Westra noted a review of Morris's records supported a finding that her "allegations are based solely on physical complaints." (R. 192) Dr. Westra observed, "Mental evaluation originated from the consulting physician's report suggesting a possible mental component, including depression. [The record] also notes that prior to filing her claim, the claimant had not sought any treatment since March 1995. This is the case, and serves to erode her credibility." (*Id.*) The doctor found that the consulting psychologist had based his report solely on Morris's self-report, without corroborating evidence, and not

on Morris's "behavior during testing." (*Id.*) Dr. Westra concluded:

The [record] indicates the claimant may have a mental impairment resulting in some of the symptoms she is alleging. However, her ADL information, her behavior at consultative exams, and absence of treatment longitudinally do not support the severity of limitations noted in the previous [Mental Residual Functional Capacity Assessment]. A review of the file is consistent with this summation.

A new [Mental Residual Functional Capacity Assessment] is completed reflecting mild to moderate limitations. . . .

(*Id.*)

Beginning on October 19, 1999, and continuing through the date of the hearing, Morris saw Sharon B. Eckhart, a psychiatric nurse practitioner, for mental health counseling. (*See* R. 227-32) Eckhart diagnosed Morris as suffering from depression, and gave her an initial GAF of 55.[(22)] She prescribed Wellbutrin. (R. 230-32) Morris saw Eckhart on November 2, November 17, December 3, and December 17, 1999; and on January 4, January 25, February 4, and March 3, 2000. Eckhart tried several different medications to find one that did not adversely affect Morris in some way. Morris tried Trazodone, Zoloft, Paxil, and finally ended up with Wellbutrin again. (R. 227-29)

During the time she was seeing Eckhart, Morris complained of trouble sleeping and restless leg problems at night, various pains, and stress. Morris stopped taking Wellbutrin after she had a possible grand mal seizure in January 2000, and on January 25, 2000, Morris reported she was exercising and feeling better. She was to remain off medications until testing was completed to determine the cause of her seizure. (R. 228) When Morris saw Eckhart on February 4, 2000, Eckhart noted Morris was "getting worked up" because testing had not revealed a cause for her seizure. Eckhart continued to advise against trying different depression medications until all the testing was complete. (R. 227) Morris was still very upset with her medical progress and a "lot of trouble trying to get on disability." (*Id.*) She reported she had further medical appointments scheduled, including one with a rheumatologist. (*Id.*) No additional records from visits with Eckhart are contained in this record.

Morris also continued to see Dr. Robison for her physical complaints. On October 20, 1999, he noted Morris had most of the symptoms of fibromyalgia[(23)], including "trigger points on her upper trapezius, along the inside of her knees and shoulder and elbow area that are consistent with fibromyalgia." (R. 222) Morris reported she was having heart palpitations, but chest x-ray and echocardiogram were both negative. She had an EKG the following month that was also negative, and Dr. Robison was unable to determine a cause for her reported heart palpitations. (R. 221) He gave Morris a prescription of Restoril to treat her restless leg syndrome. (*Id.*) On November 19, 1999, Morris reported the Restoril was helping her fibromyalgia and restless leg symptoms. (R. 220) A recheck on December 10, 1999, showed her restless leg problem was under control and Morris was seeing a chiropractor. Dr. Robison refilled prescriptions for Restoril, Flexeril and Paxil, and told Morris to follow up in three months. (R. 219) Three days later, Morris saw Dr. Robison because Morris's chiropractor had told her x-rays revealed she had an enlarged heart. Dr. Robison reassured Morris her heart workup was normal and there was no evidence of an enlarged heart. (R. 220)

On January 16, 2000, Morris was seen in the emergency room at Spencer Hospital after a possible grand mal seizure. A CT exam of her head and a brain MRI were both negative. (R. 223-24) She had an EEG on January 26, 2000, that also was normal. (R. 225) She saw Dr. Robison on January 27, 2000, for a follow-up to the seizure. He noted the CT scan, EEG and blood work had ruled out any major problems, and opined that the seizure could be related to Morris's past illicit drug use. He advised Morris to get plenty of sleep and avoid stimulants. (R. 218)

On February 10, 2000, Morris saw Dr. Philip Deffer, Jr., for evaluation of bilateral hand and finger pain. Morris evidenced positive Tinel's sign[(24)] at the carpal canal, but negative Phalen's maneuver.[(25)] X-rays of her hands and wrists were normal. Dr. Deffer concluded the hand and finger pain was "probably more related to her fibromyalgia, generalized aches and pains." (R. 214) He scheduled Morris for lab tests, CBC, sed rate, ANA[(26)], RA, urinalysis, and basic chem profile. He made Morris an appointment to see Dr. Joseph Fanciullo, a rheumatologist at the University Physicians Clinics in Sioux Falls, South Dakota. (*Id.*)

Morris saw Dr. Fanciullo on March 21, 2000. (R. 234-36) His impression of Morris was as follows:

1. Positive rheumatoid factor and mildly elevated sedimentation rate of undetermined etiology. Some of her symptoms do sound suggestive of inflammatory arthritis in the hands especially. However, there is no definite synovitis[(27)] on today's examination and therefore, no definitive diagnosis can be made. I explained this to her and stated we would have to just watch for the time being and probably treat with non-steroidal and anti-inflammatory drugs for now.

2. Fibromyalgia syndrome. This is based upon widespread tender points, poor sleep, fatigue and generalized achiness. I explained to her the best therapy for this is general conditioning program including stretching and aerobic conditioning. She is already on multiple medications for her sleep and I do not think we can do much more from that standpoint.

3. Symptoms of heat and cold intolerance and myalgias. I think we have to consider thyroid dysfunction, but overall that would be unlikely. Occasionally that does mimic fibromyalgia.

(R. 235) The doctor ordered thyroid testing and quantitative rheumatoid factor testing. He instructed her to begin an exercise program, and suggested physical therapy with stretching would be the best. He advised her to look into water therapy, but advised her "she could only go to a highly supervised program because of her seizure disorder," explaining the risks of having a seizure while she was in the water. (R. 236) He told her to take only one nonsteroidal anti-inflammatory drug at a time, and recommended she use only Vioxx and discontinue using Aleve. He recommended a follow-up in two months to "reevaluate her joints for signs of inflammatory arthritis," after Morris had started water therapy and physical conditioning. (*Id.*)

4. The ALJ's conclusion

The ALJ found Morris had not engaged in substantial gainful activity since June 1, 1995, the date she claims she became disabled. (R. 11; 24, ¶ 1; 108) He found Morris to have severe impairments "consisting of mild bilateral carpal tunnel syndrome; possible fibromyalgia; obesity; an apparent seizure disorder; and a depressive disorder, NOS," but found none of her impairments, alone or in combination, met or equaled in severity the criteria for any impairment listed in the regulations. (R. 25, ¶ 2)

The ALJ found Morris's subjective complaints of pain and her other impairments not to be credible, and not to be supported by the record to the degree Morris alleged. (R. 25, ¶ 3) The ALJ found it significant that Morris "received absolutely no medical treatment for any complaint from March 28, 1995, until the fall of 1999." (R. 12) The record supports this finding, indicating the only impetus for Morris's visits to medical practitioners between March 28, 1995, and October 19, 1999, was to obtain disability examinations. (*See* Appendix A) The ALJ found Morris's failure to seek medical treatment affected her credibility, noting:

At the time of the initial consultative physical evaluation performed on December 28, 1998, it was noted the claimant was only taking over-the-counter medication on an "as needed" basis. This lack of medical treatment during much of the relevant time frame in which the claimant alleges disability reflects negatively on the credibility to be given the claimant's assertions of various impairments, pain, and significantly reduced functional capabilities. This diminishment of the claimant's credibility is even more evident by the fact that the claimant was on ADC benefits and eligible for free medical care under Title XIX throughout the entire period at issue in this decision, the claimant's eligibility for said coverage dating as far back as at least May 1993.

(R. 12-13, internal citations omitted)

The ALJ noted Morris's initial disability claim did not mention any mental impairment or problems with headaches; however, after her initial application was denied, Morris's request for reconsideration alleged "her headaches had become more severe." (R. 13) The ALJ noted:

By the time [Morris] saw Dr. Fanciullo, a rheumatologist, on March 21, 2000, she was reporting the experience of chronic headaches with migraines about three days a week. At the hearing on March 1, 2000, she reported experiencing migraine headaches two to three times a week and having to be careful the day following the headache in order for it to go away. When present, she said sound and light are hard to deal with and she had to go to a dark room.

(*Id.*) The ALJ found it noteworthy that Morris's medical records from 1992 to March 1995 did not contain complaints of headaches, stating, "Nowhere in those treatment notes when the claimant was performing at least four different jobs at the medium, light, and sedentary exertional levels did the claimant ever allege a problem with headaches. . . ." (*Id.*) This statement is in error; the ALJ missed a reference to headache complaints Morris made to a chiropractor in January 1994. (*See* R. 203) However, this is the only record of problems with headaches prior to Morris's disability examination on December 28, 1998. The ALJ concluded:

[I]t appears on this record the claimant has concocted more allegations of impairment with resultant

functional limitation in order to buttress her claim for supplemental security income payments based on disability as her claim [h]as progressed through various levels of denial. Said factors further contribute to the diminished credibility given the claimant by the undersigned in regard to her allegations of various impairments, pain, and reduced functional capabilities.

(R. 13)

The ALJ also evaluated the evidence relating to Morris's alleged mental disability, finding her diagnosis of depression was based solely on Morris's self-reporting of symptoms, including "poor sleep, poor self-esteem, an eating disorder, and tearfulness when relating this material." (R. 19) The ALJ found no evidence to support a conclusion that Morris has "a depressive disorder resulting in significant functional limitations upon her ability to perform basic work-related activities on a regular and sustained basis." (*Id.*) He noted Morris might be expected to complain of poor self-esteem, based on her "life history and life circumstances," but concluded, "By the same token it would not, in and of itself, necessarily result in significant depressive symptomatology interfering with the claimant's ability to perform basic work-related activities." (R. 19-20)

The ALJ pointed to several other inconsistencies between Morris's subjective pain complaints and the evidence in her medical records. (*See* R. 14-20) The ALJ noted he was "giving the benefit of the doubt to the claimant in some degree as to her assertions of pain," and ultimately found Morris to have severe impairments as noted above, none of which, singly or in combination, met the regulatory criteria.

In summary, the ALJ found Morris's subjective complaints, as well as the testimony of Morris's mother regarding Morris's condition, not to be credible, "and not substantially supported by medical evidence and opinion in record to the degree alleged." (R. 23) He also noted Morris's poor work history and the fact that she had been on ADC since at least May 1993, concluding Morris's "motivation to work is questionable on this record." (*Id.*) Considering the record as a whole, the ALJ found Morris retained the residual functional capacity to perform light and sedentary work, specifically:

work-related activities except for work involving lifting or carrying weight above the light exertional level; performing postural activities on more than an occasional basis; sitting, standing, or walking for prolonged periods of time; performing highly repetitive activity; and performing work at heights or around dangerous machinery.

(R. 25, ¶ 4) Noting Morris's past relevant work as assistant manager of Claire's and as a telemarketer did not require activities precluded by these limitations, the ALJ found Morris could perform her past relevant work. (*Id.*, ¶¶ 5 & 6) He therefore concluded Morris was not disabled, and denied benefits without proceeding to step five of the sequential analysis. (*Id.*, ¶ 7)

III. APPLICABLE LAW

A. Disability Determination, Burden of Proof, and Substantial Evidence Standard

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering . . . his age, education and work experience, engage in any other kind of substantial gainful work which exists in [significant numbers in] the national economy . . . either in the region in which such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley*, 133 F.3d at 587-88 (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *Hunt v. Heckler*, 748 F.2d 478, 479-80 (8th Cir. 1984) ("[O]nce the claimant has shown a disability that prevents him from returning to his previous line of work, the burden shifts to the ALJ to show that there is other work in the national economy that he could perform.") (citing *Baugus v. Secretary of Health & Human Serv.*, 717 F.2d 443, 445-46 (8th Cir. 1983); *Nettles v. Schweiker*, 714 F.2d 833, 835-36 (8th Cir. 1983); *O'Leary v. Schweiker*, 710 F.2d 1334, 1337 (8th Cir. 1983)).

Step five requires that the Commissioner bear the burden on two particular matters:

In our circuit it is well settled law that once a claimant demonstrates that he or he is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added) *accord Weiler*, 179 F.3d at 1110 (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and

capabilities).

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Hutsell v. Massanari*, ___ F.3d ___, 2001 WL 863620, slip op. at 6 (8th Cir. Aug. 1, 2001) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)*; Haley v. Massanari*, ___ F.3d ___, 2001 WL 868050 at *4 (8th Cir. Aug. 2, 2001). As the *Hutsell* court explained:

Substantial evidence is less than a preponderance, but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion. [Citation omitted.] In determining whether existing evidence is substantial, we consider evidence that detracts from the Commissioner's decision as well as evidence that supports it. *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000). As long as there is substantial evidence on the record as a whole to support the Commissioner's decision, we may not reverse it because substantial evidence exists in the record that would have supported a contrary outcome, *id.*, or because we would have decided the case differently, *Browning v. Sullivan*, 958 F.2d 817. 822 (8th Cir. 1992).

Hutsell, supra; see Haley, supra; Richardson v. Perales, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992) (citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently," *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)), because the court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

B. The Polaski Standard: Subjective Pain Complaints and Credibility Determination

Although some courts disagree,[(28)] in the Eighth Circuit, an ALJ may not discredit pain allegations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective pain complaints if they are inconsistent with the record as a whole. *Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). Under *Polaski:*

The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

1) the claimant's daily activities;

2) the duration, frequency and intensity of the pain;

3) precipitating and aggravating factors;

4) dosage, effectiveness and side effects of medication;

5) functional restrictions.

Polaski, 739 F.2d at 1322.

IV. ANALYSIS

As noted above, the court's primary task in this case is to determine whether the ALJ's decision is supported by substantial evidence, considering the record as a whole. This is the type of case where two inconsistent positions are possible to draw from the evidence. The court recognizes there are some inconsistencies between Morris's subjective pain complaints and documentary evidence in the record. On the other hand, the court does not give much weight to the ALJ's reliance upon the increase in Morris's symptoms during the pendency of her application. Fibromyalgia being the amorphous illness that it is, someone with the illness could be expected to develop more symptoms over time, and/or to have various and changing symptoms over time.

Morris complains that the ALJ favored the evaluations of persons conducting only a 'paper review' over the opinion of Dr. Mayhew, who evaluated Morris 'in person.' (*See* Doc. No. 8, p. 5) Nevertheless, Dr. Mayhew was not a treating physician, and his opinion is entitled to no special deference. *See Prosch v. Apfel*, 201 F.3d 1010, 1012-13 (8th Cir. 2000); *Wiekamp v. Apfel*, 116 F. Supp. 2d 1056, 1073-74 (N.D. Iowa 2000).

While this court "might have weighed the evidence differently" in this case, nevertheless, the court lacks the authority to reverse the Commissioner's decision on that basis, even where the court finds substantial evidence in the record to support a different conclusion. *Culbertson, supra; Spradling, supra*. Furthermore, the ALJ overcame his obvious contempt for Morris and reached conclusions based on his evaluation of the evidence in the record, carefully documenting his reasoning. The court is unable to substitute its own evaluation for the ALJ's under these circumstances, and finds substantial evidence exists to support the Commissioner's decision.

V. CONCLUSION

For the reasons discussed above, **IT IS RECOMMENDED**, unless any party files objections[(29)] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of the Commissioner and against Morris.

IT IS SO ORDERED.

DATED this 29th day of August, 2001.

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PAUL A. ZOSS

MAGISTRATE JUDGE

UNITED STATES DISTRICT COURT

APPENDIX A

MEDICAL RECORDS SUMMARY

***Morris v. Massanari*, Case No. C00-4164-MWB**[(30)]

DATE	MEDICAL PRACTITIONER/ FACILITY	COMPLAINTS	DIAGNOSIS, TREATMENT & COMMENTS
04/22/93 R. 201	David P. Robison, D.O. Mercy Family Care - Spencer	Bilateral wrist pain; tenderness and weakness in left hand more than right; numbness at night; mid and low back pain.	Negative Phalen's[(31)] and Tinel's[(32)] on the right; positive Phalen's and negative Tinel's on left. Grip strengths equal and bilaterally symmetric. Back pain due to posture and obesity. Assessment: median neuritis of left wrist. Treatment: Applied wrist splint;

			gave samples of Ansaid.[33] Follow up 7-10 days.
05/03/93 R. 201	David P. Robison, D.O. Mercy Family Care - Spencer	Wrist is better when wearing splint, but hand is getting weak as she hasn't been using it.	Assessment: Classic signs and symptoms of carpal tunnel. Treatment: Schedule EMG studies.
05/11/93 R. 198	David P. Robison, D.O. Mercy Family Care - Spencer		Assessment: EMG reveals mild bilateral carpal tunnel. Treatment: Schedule appt with physical therapy; Rx for Naprosyn.[34] Follow up in two weeks.
01/04/94 01/21/94 R. 203	V.G. Rients D.C. Graettinger Clinic of Chiropractic	Low back pain, cervical pain and headaches.	Office visits - no treatment notes.
03/23/95 R. 198	David P. Robison, D.O. Mercy Family Care - Spencer	Upper back and neck stiffness and pain following visit to chiropractor.	Assessment: Tenderness in paraspinal muscles in cervical spine area. Only able to flex to 30°. Treatment: Rx for Motrin and Flexeril[35]; stop visits to chiropractor; use heat or cold. Follow up in one week.
03/27/95 R. 198	David P. Robison, D.O. Mercy Family Care - Spencer	Follow-up visit.	Neck is much better; "pretty good" ROM, but after ½ day at work, she stiffens up and continues to have problems with carpal tunnel and tendinitis. Treatment: Look for different job that does not require sitting at a desk for extended periods of time.
06/01/95 **R. 108**	**MORRIS'S CLAIMED DISABILITY ONSET DATE**		
12/28/98 R. 195-96	Brian J. Dvorak, M.D. Mercy Family Care	Referred for disability determination exam	Patient states she has carpal tunnel syndrome > five years which has gradually worsened; tendinitis in wrists and forearms; chronic neck pain since age 1, worsening with prolonged sitting or bending forward; low back pain for years which worsens with bending and lifting. Able to lift from waist to shoulder with 5 lbs in both hands repetitively. Shaky and complains of discomfort in forearms and did not want to try anything heavier than 5 lbs.

			From floor to waist, she could lift a basket weighing 19 pounds, but it caused pulling in her low back. Assessment: bilateral carpal tunnel syndrome; chronic neck and low back pain, suspect musculoskeletal/mechanical back pain; chronic headaches; possible common migraines. Treatment: Encouraged Patient to follow up with primary care provider re add'l treatments.
01/18/99 R. 194	Brian J. Dvorak, M.D. Mercy Family Care	Chronic low and upper back pain present for years; chiropractic not resolving problem.	Assessment: Chronic back pain and obesity. Treatment: Referred for physical therapy on back; suggested starting an aerobics program; referred to dietician for weight reduction. Follow up in one month.
01/29/99 R. 193	Jon S. Hade, M.D. Mercy Family Care - Spencer	Disability exam; back pain, wrist pain, carpal tunnel	Lumbar spine x-ray reveals mild degenerative changes at L4 and L5. Bilateral wrist x-rays reveal approx. 7 mm of relatively symmetric ulna minus bilaterally-of uncertain clinical significance.
02/12/99 R. 164-73	Dennis A. Weis, M.D.	Residual Physical Functional Capacity Assessment	Found Morris can occasionally lift/carry 20 pounds; frequently lift/carry 10 pounds; stand, walk, sit about 6 hours in 8-hr. workday; push/pull - no limitation; occasional limitations on climbing, balancing, stooping, kneeling, crouching, crawling; no manipulative, visual, communicative, environmental limitations.
05/27/99 R. 208	M.E. McKenney, M.D. Buena Vista Clinic	Cervical spine x-ray	No evidence of fracture or dislocation; no evidence of disc disease or significant arthritis; mild neck scoliosis.
06/01/99 R. 204-07	Dave Archer, M.D. Buena Vista Clinic	Disability evaluation (continued on next page)	"[Morris] was a difficult, circuitous and somewhat evasive historian." Impression: Somatization disorder(36) by DSM IV criteria; possible major depression; cannabis use, continuous; morbid obesity; deconditioning syndrome.(37) "[P]atient should have no difficulty lifting and carrying except as limited

			by her weight and conditioning, but her current mental state will prevent her from any significant activity at all due to very poor motivation.
06/01/99 R. 204-07	Dave Archer, M.D. Buena Vista Clinic	Disability evaluation (continued)	She should have no difficulty with handling, environment or special senses, at least physically. This lady believes herself to be totally disabled, but cannot explain why to me in any organized manner. She does not express a belief that there is any effective treatment and has declined treatment in the past. I would recommend pursuit of psychological evaluation for further refinement of diagnosis and treatment recommendations[.] . . . [S]he will require some degree of work hardening before she returns to active employment. Physically, however, there should be no problem."
08/03/99 R. 211-12	Steven B. Mayhew, Ph.D.	Psychological Evaluation (continued next page)	Impression: Axis I: Depressive Disorder; Axis II: deferred; Axis III: Neck and back pain, obesity, migraine headache; Axis IV: limited education, unemployment, limited job skills; Axis V: GAF=40 (current)(38). Recommendations: May meet criteria for an undifferentiated somatoform disorder,(39) though only provisional based upon today's exam. Ability to remember and understand instructions is fair; some difficulty listening carefully to questions and needed to be redirected, which would likely happen in the workplace. "[S]he would have difficulty carrying out instructions on a consistent and reliable basis. Her immediate attention and concentration is fair, however, her sustained concentration and work pace is expected to be poor. She would appear to interact appropriately with supervisors, but would not do so with the general public.
08/03/99	Steven B. Mayhew, Ph.D.	Psychological Evaluation (continued)	Judgment is estimated to be fair to poor. Her ability to respond to

R. 211-12			changes in the work place is estimated to be limited. It is recommended that she be considered eligible for disability benefits at this point, though medical records from Dr. Robison should be obtained and, if awarded benefits, that these be managed by a payee."
08/13/99 R. 174-78	Philip R. Laughlin, Ph.D.	Functional Capacity Assessment (continued on next page)	No significant limitation in ability to: remember locations and work-like procedures; understand and remember very short and simple instructions; ask simple questions or request assistance; travel in unfamiliar places or use public transportation. Marked limitation in ability to: carry out detailed instructions; maintain attention and concentration for extended periods and perform activities within a schedule; maintain regular attendance and be punctual within customary tolerances; work in coordination with or proximity to others without being distracted by them; complete a normal work-day and work week without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; respond appropriately to changes in the work setting.
08/13/99 R. 174-78	Philip R. Laughlin, Ph.D.	Functional Capacity Assessment (continued)	Moderate limitation in ability to: understand and remember detailed instructions and carry out very short and simple instructions; sustain an ordinary routine without special supervision and make simple work-related decisions; interact appropriately with the general public; accept instructions and respond appropriately to criticism from supervisors; get along with coworkers or peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness; be aware of normal hazards and take appropriate

			precautions; set realistic goals or make plans independently of others. Conclusion: The MDI is depressive disorder, possibly coupled with an undifferentiated somatoform disorder.(40) Impairment is severe based upon the impairment findings and symptoms and the consistency of the file. Claimant does not meet or equal Listing Impairment. Evidence is consistent with the allegations; no inconsistencies across sources of information are noted. The claimant does manifest significant restrictions of function with sustained pace, concentration and attention, and adaptation/executive function.
08/13/99 R. 179-87	Philip R. Laughlin, Ph.D.	Psychiatric Review Technique	RFC assessment necessary(41) based upon affective disorders, somatoform disorders. No evidence of organic mental disorders; schizophrenic, paranoid, and other psychotic disorders; mental retardation, autism, or anxiety related disorders; personality disorder or substance abuse disorders. Disturbance of mood, accompanied by a full or partial manic or depressive syndrome evidenced by depressive disorder. Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms evidenced by provisional-undifferentiated somatoform disorder. Activities of daily living and maintaining social functioning are moderately limited. Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner are frequent; no limitations regarding episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms.
09/27/99	Beverly Westra, Ph.D.	Mental Residual	No significant limitation in ability to:

R. 188-92		Functional Capacity Assessment (continued on next page)	remember locations and work-like procedures; understand and remember very short and simple instructions; carry out very short and simple instructions; perform activities within a schedule; maintain regular attendance and be punctual within customary tolerances; sustain an ordinary routine without special supervision; work in coordination with or proximity to others without being distracted by them; make simple work-related decisions; interact appropriately with the general public; ask simple questions or request assistance; accept instructions and respond appropriately to criticism from supervisors; get along with coworkers or peers without distracting them or exhibiting behavioral extremes; maintain socially appropriate behavior; adhere to basic standards of neatness and cleanliness; be aware of normal hazards and take appropriate precautions; travel in unfamiliar places or use public transportation. Moderate limitation in ability to: understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal work-day and work week without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; respond appropriately to changes in the
09/27/99 R. 188-92	Beverly Westra, Ph.D.	Mental Residual Functional Capacity Assessment (continued)	work setting; set realistic goals or make plans independently of others. DQB notes evidence does not support the previous MRFC, and the claimant retains the mental capacity to return to her past relevant work. DQB notes allegations are based solely on physical complaints. Mental evaluation originated from the

			consulting physician's report suggesting a possible mental component, including depression. DQB also notes that prior to filing her claim, the claimant had not sought any treatment since March 1995. This serves to erode her credibility. DQB indicates claimant may have a mental impairment resulting in some of the symptoms alleged but ADL information, her behavior at consultative exams, and absence of treatment do not support the severity of limitations noted in the previous MRFC.
10/19/99 R. 230-32	Sharon B. Eckhart, ARNP Spencer Psychiatry	Intake Assessment; referral for treatment of depression. Complaints of poor sleep, tearfulness, poor self esteem, eating disorder.	Impression: Axis I: Depression, NOS, with atypical manifestations; Axis II: deferred; Axis III: Chronic back pain by self report; Axis IV: Difficulty obtaining a job; recent deaths of friends; Axis V: GAF: 55 (current).(42) Treatment: Given Rx for Wellbutrin.(43) Follow up for assessment of response and side effects. Encourage continuing therapy.
10/20/99 R. 222	David P. Robison, D.O. Mercy Family Clinics-Spencer	Possible fibromyalgia; intermittent heart palpitations, frequent urination w/dysuria.(44)	Assessment: Patient has most of the symptoms of fibromyalgia(45), including "trigger points on her upper trapezius, along the inside of her knees and shoulder and elbow area that are consistent with fibromyalgia". Chest x-ray appears normal; EKG normal. HIV test negative; echocardiogram negative. Treatment: Rx for Flexeril(46) & Flagyl.(47) Follow up in 7-10 days.
11/02/99 R. 221	David P. Robison, D.O. Mercy Family Clinic - Spencer	Recheck for heart palpitations. Complains legs are moving around at night in bed.	Assessment: EKG appears normal; "no real reason for her heart palpitations"; possible restless leg syndrome. Treatment: Give her heart card to see if palpitations can be recorded. Rx for Restoril.(48) Follow up in 3-4 weeks.
11/02/99 R. 229	Sharon B. Eckhart, ARNP	Medication check and therapy	Patient states she's unable to increase Wellbutrin. Current dosage is helping some but gives her stomachaches and

	Spencer Psychiatry		headaches. Continues to have trouble sleeping and restless leg problems at night. Would like to try Zoloft. Treatment: Given Rx for Trazodone[49] and Zoloft.[50] Discontinued Wellbutrin.
11/17/99 R. 229	Sharon B. Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient appears older than stated age and fatigued. Has had no side effects from Zoloft but doesn't feel as well as she did on Wellbutrin. On the BECK Anxiety and Depression Scale,[51] patient scores in the severe range. Treatment: Increase dosage of Zoloft. Follow up in two weeks.
11/19/99 R. 220	David P. Robison, D.O. Mercy Family Clinic-Spencer	Recheck	Restoril is helping fibromyalgia and restless leg syndrome. Psychiatrist has switched patient from Wellbutrin to Zoloft.
12/03/99 R. 228	Sharon B. Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient states she can't tolerate Zoloft; very emotional and wonders if she has bipolar disorder. Treatment: Switch to Paxil.[52] Follow up in two weeks.
12/10/99 R. 219	David P. Robison, D.O. Mercy Family Clinics-Spencer	Recheck. Restless leg problem under control; continues to see chiropractor as needed.	Treatment: Continue to see chiropractor as indicated; continue Restoril, Flexeril, Paxil. Recheck in 3 months.
12/13/99 R. 220	David P. Robison, D.O. Mercy Family Clinic-Spencer		Patient's chiropractor says x-ray reveals enlarged heart; reassured her heart workup was normal and there was no evidence of cardiomegaly.[53]
12/17/99 R. 228	Sharon B. Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient appears fatigued. Complains she's in much pain and is concerned about her physical health. Unable to tolerate Paxil and wants to try Wellbutrin again. Treatment: Switch to Wellbutrin. Follow up in two weeks.
01/04/00 R. 228	Sharon B. Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient tearful due to stressful couple of weeks; "tends to get herself into positions where she feels overwhelmed and then ends up with physical problems of the fibromyalgia." Continue on Wellbutrin and follow up in two weeks.
01/16/00	Jon Hade, M.D.	Head CT & MRI	Impression: Unremarkable head CT

R. 223-24	Spencer Hospital	following seizure	exam. Negative brain MRI without contrast.
01/25/00 R. 228	Sharon B. Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient indicates she is feeling better and is spending more time walking, stretching and working on physical self. Patient had seizure and has had no meds for one week. Treatment: Remain drug free until workup is completed determining cause of seizure.
01/26/00 R. 225	Jerome Freeman, M.D. Neurology Associates, PC	EEG	Impression: EEG is within normal limits. No cerebral irritative features or other abnormalities.
01/27/00 R. 218	David P. Robison, D.O. Mercy Family Clinics-Spencer	Follow-up to ER visit for seizure	Patient seen in ER for possible grand mal seizure. CT scan and blood work ruled out major problems. EEG normal. Could be related to prior illicit drug use (cocaine, LSD, PCP, marijuana). Treatment: Avoid stimulants and get sufficient sleep.
02/04/00 R. 227	Sharon B. Eckhart, ARNP Spencer Psychiatry	Med check and therapy	No further seizures, but patient is "getting worked up" as they have not found anything concrete. Recommend she not try different meds for depression until there's a diagnosis re neurological condition.
02/10/00 R. 214	Philip Deffer, Jr., M.D. NW Iowa Bone, Joint & Sports Surgeons	Bilateral hand and finger pain.	No Tinel's(54) at cubital tunnel; negative elbow and flexion test. Positive Tinel's at the carpal canal but negative Phalen's(55). No atrophy. X-rays of hands and wrists are normal. Assessment: "[T]his is probably more related to her fibromyalgia, generalized aches and pains." Treatment: Obtain lab tests and follow up in two weeks.
02/24/00 R. 213	Philip Deffer, Jr., M.D. NW Iowa Bone, Joint & Sports Surgeons	Follow-up for bilateral hand pain after obtaining labs. Multiple joint complaints besides hands; knees are bothering her.	Rheumatoid factor is positive; sed rate is 33; ANA is negative.(56) Treatment: Schedule appt with rheumatologist.
03/03/00 R. 227	Sharon Eckhart, ARNP Spencer Psychiatry	Medication check and therapy	Patient very upset due to medical problems and difficulty obtaining disability. Still having problems sleeping. Medical workup needs to be completed before changing meds.

			Follow up as needed.
03/21/00 R. 234-36	Joseph Fanciullo, M.D. University Physicians Clinics	Referred for evaluation of musculoskeletal complaints	Impression: Positive rheumatoid factor; mildly elevated sed rate of undetermined etiology; possible inflammatory arthritis in hands, but no definitive diagnosis based on lack of definite synovitis(57) on exam. Fibromyalgia syndrome "based upon widespread tender points, poor sleep, fatigue and generalized achiness." Symptoms of heat and cold intolerance and myalgias. Treatment: Check TSH and T_4 and quantitative rheumatoid factor; start exercise program and physical therapy with stretching and aerobic conditioning. Recommended water therapy but only under supervision. Advised to discontinue Aleve and continue on Vioxx. Follow up in two months.

1. This case was filed originally against Kenneth S. Apfel, who was at that time Commissioner of the Social Security Administration. On March 29, 2001, Larry G. Massanari became Acting Commissioner of the Administration, and he is therefore substituted as the defendant in this action. *See* Fed. R. Civ. P. 25(d)(1); *cf.* Fed. R. App. P. 43(c)(2).

2. Morris testified her husband died October 3, 1999, after they had been married almost 17 years. (R. 39) However, Morris and her husband had been separated for nearly ten years before the latter's death, and he had not supported Morris and her children for at least ten years preceding the hearing. (*Id.*)

3. The transcript refers variously to "Dr. Robinson," "Dr. Roberson," and "Dr. Robertson." The medical records indicate these references should be to David P. Robison, D.O., who treated Morris from April 1993, through January 2000. *See* Appendix A, Medical Records Summary.

4. *See* Appendix, note 6.

5. *See* Appendix, note 18.

6. *See* Appendix, note 7.

7. Both the ALJ and Morris referred to Sharon Eckhart as a doctor, and Morris's attorney even stated Eckhart is "a psychiatrist." (*See* R. 74) The medical records indicate Eckhart actually is a Psychiatric Nurse Practitioner. *See* R. 232.

8. Trazodone is used to treat depression. *See, e.g.*, "Desyrel," *Physicians' Desk Reference*, 503 (50th ed. 1996).

9. The only evidence in the file suggesting Morris was using marijuana is in the notes of the consultative disability evaluation on June 1, 1999, where Dr. Dave Archer noted, under "Social history," that Morris was a "nonsmoker, does not drink alcohol, but openly admits she smokes marijuana to relieve her pain." (R. 205) Dr. Archer's impressions included "Cannabis use, continuous." (R. 207) There are numerous references in the record to Morris's prior drug use when she lived in California, but no further references to any recent use of marijuana or other illicit drugs. The court finds no reason to doubt Morris's testimony that she had been clean for ten years as of the time of the hearing. And in any event, despite what he termed as Morris's contradictory reports of her drug use, the ALJ found, due to lack of evidence in the record, that Morris did not have a substance abuse disorder, and "drug abuse and/or alcoholism does not constitute a 'material' factor contributing to a finding of disability in this case." (R. 22)

The court notes the ALJ exhibited a general attitude of disdain when he questioned Morris at the hearing. (*See* R. 70-71). For example, this attitude is illustrated by the following exchange:

A I did have jobs in California.

Q No, you didn't. I'm looking at your record back to 1978.

A I had a job at General Design in Van Nuys, California.

Q What year was that?

A I do believe that was about 1982.

Q You made $768, that was pretty impressive.

(*Id.*)

10. *See* R. 13, where the ALJ noted, *inter alia*, that Morris "has concocted more allegations of impairment with resultant functional limitation in order to buttress her claim for supplemental security income payments based on disability as her claim [h]as progressed through various levels of denial."

11. Head, eyes, ears, nose, throat.

12. "Dyspnea" is labored breathing. *Dorland's Illustrated Medical Dictionary*, 520 (27th ed. 1988).

13. Genitourinary.

14. "Tenesmus" is "straining, especially ineffectual and painful straining at stool or in urination." *Dorland's Illustrated Medical Dictionary*, 1670 (27th ed. 1988).

15. "Scintillating scotoma," or "teichopsia," is "the sensation of a luminous appearance before the eyes, with a zigzag, wall-like outline." *Dorland's Illustrated Medical Dictionary*, 1667, 1498-99 (27th ed. 1988).

16. *See* Appendix A, notes 2 & 3.

17. *See* Appendix A, note 7.

18. *See* note 9, *supra*.

19. *See* Appendix A, note 8.

20. *See* Appendix, note 9.

21. *See* Appendix, note 10.

22. *See* Appendix, note 13.

23. *See* Appendix, note 15.

24. *See* Appendix, note 3.

25. *See* Appendix, note 2.

26. *See* Appendix, note 27.

27. *See* Appendix, note 28.

28. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987).

29. Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

30. Only those medical records relevant to Morris's disability claim are summarized in detail. Records not related to her claimed disability have been truncated or omitted.

31. "Phalen's maneuver" is used to detect carpal tunnel syndrome. It involves reducing the size of the carpal tunnel "by holding the affected hand with the wrist fully flexed or extended for 30 to 60 seconds, or by placing a [blood pressure] cuff on the involved arm and inflating to a point between diastolic and systolic pressure for 30 to 60 seconds." *Dorland's Illustrated Medical Dictionary* (27th ed. 1988) ("*Dorland's*"), 978.

32. "Tinel's sign" is "a tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or the beginning regeneration of the nerve." *Dorland's*, 1526.

33. Ansaid is a nonsteroidal anti-inflammatory drug. *Physicians' Desk Reference* (50th ed. 1996) ("*PDR*"), 2579.

34. Naprosyn is a nonsteroidal anti-inflammatory drug. *PDR*, 2110.

35. "Flexeril is indicated as an adjunct to rest and physical therapy for relief of muscle spasm associated with acute, painful musculoskeletal conditions." *PDR*, 1661.

36. "Somatization disorder" is "classic hysteria (Briquet's syndrome); a mental disorder characterized by multiple somatic complaints that are not caused by a real physical illness; the complaints may involve a general complaint of being sickly or specific conversion (pseudoneurological) symptoms, gastrointestinal symptoms, female reproductive symptoms, psychosexual symptoms, cardiopulmonary symptoms, or pain. Complaints are often presented in a dramatic, vague, or exaggerated way; many physicians become involved in the medical care; and numerous diagnostic evaluations and unnecessary medical treatment or surgery may be performed. Most patients have symptoms of anxiety and depression and a wide range of interpersonal difficulties; many have histrionic (hysterical) personality traits." *Dorland's*, 498.

37. "Deconditioning syndrome" occurs when someone significantly curtails daily physical activity as a response to pain, essentially causing them to "get out of shape." *See* R.W. Hansen, Ph.D.,"Self Management of Daily Physical Activities," at www.long-beach.med.va.gov/Our_Services/Patient_Care/cpmpbook/cpmp-12.html (visited 08/03/01). For example, as it relates to back pain:

The natural reaction to back pain is to block or guard any movements that require the back to work. This will temporarily prevent the back musculature from being exposed to external forces. Doing this relieves short-term pain, but the long-term effects can be devastating. Pain leads to disuse; disuse leads to muscular atrophy; atrophy leads to weakness. Weakness predisposes an individual to recurrent injury because of the inability to withstand normal usage. This continuous cycle is referred to as the chronic deconditioning syndrome.

B. Holmes, "The lowdown on back pain" (Sat. Eve. Post March-Apr. 1998), found at www.findarticles.com/cf 0/m1189/n2 v270/21021493/p1/article.jhtml (visited 08/03/01).

38. "A GAF score is a rough estimate of an individual's psychological, social, and occupational functioning used to reflect the individual's need for treatment. *Diagnostic and Statistical Manual of Mental Disorders* 20 (3rd. ed., rev. 1987)." *Vargas v. Lambert*, 159 F.3d 116, 1164 (9th Cir. 1998). The GAF scale goes from 0-90. . . . [A GAF of] 31-40 [indicates] some impairment in reality testing or communication or major impairment in several areas such as work, family relations, and judgment." *Bartrom v. Apfel*, 234 F.3d 1272 (Table), 2000 WL 1412777, at *1 n.3 (7th Cir. Sept. 20, 2000).

39. "Somatoform disorder" is a "mental disorder[ ] characterized by symptoms suggesting a physical disorder that are of psychogenic origin but not under voluntary control[.]" *Dorland's*, 498.

40. *Id*.

41. "RFC Assessment Necessary (i.e., a severe impairment is present which does not meet or equal a listed impairment)." R. 179

42. *See* note 9, *supra*. "A GAF score of 55 indicates at least moderate symptoms or moderate difficulty in [psychological], occupational, or social functioning. *Id.* at 12." *Vargas v. Lambert*, 159 F.3d 116, 1164 (9th Cir. 1998).

43. Wellbutrin is an antidepressant. *PDR*, 1204-05.

44. "Dysuria" is "painful or difficult urination." *Dorland's*, 522.

45. "Fibromyalgia," also known as fibrositis, is "a common, but elusive and mysterious, disease, much like chronic fatigue syndrome, . . . Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective." *Sarchet v. Chater*, 78 F.3d 305, 306 (7th Cir. 1996). It causes pain in the fibrous connective tissue components of muscles, tendons, ligaments, and other white connective tissues. *Cline v. Sullivan*, 939 F.2d 560, 563 (8th Cir. 1991).

46. *See* note 6, *supra*.

47. Flagyl contains metronidazole, "an oral synthetic antiprotozoal and antibacterial agent," used to treat a number of infections. *See PDR*, 2434-45.

48. Restoril, a brand name for Temazepam, is "a benzodiazepine hypnotic agent" used in the short-term treatment of insomnia." *PDR*, 2284.

49. Trazodone is an antidepressant. *See, e.g.*, "Desyrel," *PDR*, 503.

50. Zoloft is an antidepressant. *PDR*, 2217.

51. The "Beck Depression Inventory" is "a screening measure for depressive symptoms and distinguishes between vegetative symptoms and characteristics of psychological and emotional discomfort. It also measures suicidal ideation and plans." Hunter, Larrieu, Ayad, O'Leary, Griffies, DeBlanc, & Martin, "Roles of Mental Health Professionals in Multidisciplinary Medically Supervised Treatment Programs for Obesity," found at www.sma.org/smj/97june2.htm (visited 08/03/01).

52. Paxil is an antidepressant. *PDR*, 2505.

53. "Cardiomegaly," or "cardiac hypertrophy," is an enlarged heart. *See Dorland's*, 274, 800.

54. *See* note 3, *supra*.

55. *See* note 2, *supra*.

56. "ANA" means antinuclear antibodies. If someone is positive for antinuclear antibodies, they have antibodies that are "destructive to or reactive with components of the cell nucleus[,]" *Dorland's*, 69, 104, indicating a particular condition (*e.g.*, lupus erythematosus).

57. "Synovitis" is "inflammation of a synovial membrane. It is usually painful, particularly on motion, and is characterized by a fluctuating swelling due to effusion [*i.e.*, escaping fluid; *see id.* at 532] within a synovial sac." *Dorland's*, 1649. A "synovial membrane" secretes synovial fluid, "a transparent alkaline viscid fluid, resembling the white of an egg, . . . contained in joint cavities, bursae, and tendon sheaths; called also synovial fluid." *Dorland's*, 1648-49.